Philosophizing in Clinical Practice: From “Patient-Centered” to “Loving Struggle”

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Much of modern philosophy is informed by clinical practice in psychopathology and advanced medicine, but what about the reverse? What is modern philosophy’s contribution to medicine and clinical practice? One such contribution is in the creation of bioethical standards, such as the concepts of dignified death and brain death, and bioethical reviews for clinical research. However, establishing guidelines based on ethical standards is not a complete solution for individual clinical cases presenting philosophical or ethical questions; rather, overly systematic ethical standards impede patients’ free thought and may prove to be a barrier to finding the optimum in a particular clinical scenario. This paper does not provide valuable data for understanding the human condition by “philosophizing *based on* clinical practice,” nor does it aim to set out standards by “philosophizing *about* clinical practice”: it explores the significance and methods of “philosophizing *in* clinical practice” as carried out by those involved and presents new findings on the relationship between modern philosophy and clinical practice.

1. The Patient-Centered Approach

Veatch postulates four categories–the Engineering Model, the Priestly Model, the Collegial Model, and the Contractual Model–for an ideal physician-patient relationship,[1] while Beauchamp and Childress present four general principles–“respect for autonomy,” “beneficence,” “non-maleficence,” and “justice”[2]–as guiding principles for medicine[3] in their *Principles of Biomedical Ethics*. Modern medicine has been led by historical reflection and a rise in societal awareness of human rights to reconsider its long-standing paternalism, wherein physicians are given full authority over their patients and determine all courses of treatment, but, as evident in the Hippocratic oath of ancient times, the historical, underlying attitude and ideology among medical practitioners has been one of using their own capacities to provide care “on the patient’s behalf.” In other words, while the subject of optimum choices for the patient and the decision-making process are undergoing change, medical treatment continues to be an act on behalf of the patient. If we accept Parsons’ statement that a “service may be defined most generally as any act of an individual insofar as it contributes to the realization of the ends of other individuals,”[4] then medical practice is a service carried out by professional bodies (medical practitioners) to realize the act of treating a patient’s illness. In other words, medical practice may be described as a social act wherein the patient is the object of the service.[5] When medical practice is thus positioned as the social act of professional bodies granted specific qualifications, it is accompanied by responsibilities and thus enters the public realm.

With the advancements in medical techniques, the emergence of various treatment methods and possibilities, and when with quality of life (QOL) becoming an important aspect among the various options, "patient focused medicine" and "patient rights" have become important issues. This is typified in medical care for terminally ill patients with untreatable illnesses: clinical practice in palliative care and hospice care.

When faced with the prospect of impending death, terminally ill patients experience a range of losses. For example, cancer patients may experience an anguished sense of losing their human dignity as they gradually and painfully lose physical function, become unable to live independently, or can no longer eat or excrete waste. Further, as their illness progresses, patients lose the social standing attached to the jobs, roles, and other positions that they have hitherto fulfilled. This leads to the loss of various prior human connections. Such losses experienced by terminally ill patients are fundamentally unrecoverable and will continue until death. In addition, practical responsibilities like inheritance and the livelihoods of their surviving families can add further pressure. As end-of-life care requires responding to the various forms of loss and suffering experienced by such patients, palliative care is provided by teams comprising a range of specialists. Officially, patients' physical treatment and assistance are provided by doctors and nurses, while the social aspect is covered by social workers, and the psychological side by psychiatrists and clinical psychologists, with each professional body making full use of its capacities to eliminate as much suffering as possible by close communication with patients and their families. However, while a role is assigned to each specialist, wholesome care cannot be provided by a system that follows complete division of labor. As in cases of physical pain engendering psychological depression or psychological depression lowering immune function, loss and suffering of different types interact with one another as they accumulate. Patients do not feel each of these forms of suffering separately, but experience them as "total pain." Therefore, we need "holistic care" that considers individual circumstances and symptoms as a whole rather than separately and follows an appropriate course of action with consideration for balance. To do this, we also need cooperation among specialist colleagues. Furthermore, the guiding principle of "respect for autonomy" posits that the final criterion in the judgment of what is appropriate and optimal rests with the patient him/herself, rather than with the doctor, meaning that modern medicine requires a structure in which the patient, while the object of treatment, provides the basis for decision-making, whereby the specialists approach the patient's experiences and, in collaboration, demonstrate their individual capacities. This is what is known as the "patient-centered approach." Positioning respect for the patient's autonomy as a guiding principle, modern medicine has seen patient-centered approaches applied to all clinical practices. In the case of end-of-life care, which looks for *ways to attend patients to the last* rather than aim for cure through treatment, this approach is practiced under a clear framework whereby the patient's specific circumstances and decision-making are supported by the attending team, as opposed to being treated as a one-size-fits-all option provided by doctors specializing in cure.

2. Philosophical Suffering in Patients

Among the various categories of suffering experienced by terminally ill patients is the suffering provoked by an awareness of their own death. Modern medicine can certainly prolong the life of the patient, but it cannot completely conquer mortality. Feelings of fear, anxiety, and hopelessness

regarding death thus arise instinctively in all living creatures, and, since these feelings are not abnormal, they are not problems to be resolved psychiatrically. Suffering in the face of death is not exclusive to terminally ill patients but is an emotion that may be experienced at any time by anyone, sharing as we do the same human fate. It is a universal philosophical and religious question, not being limited to death itself, but encompassing the resulting, inescapable contemplation of the meaning of life and the view of life and death. In other words, this suffering in the face of death is a potentially unresolvable issue that transcends the treatment framework. Although beyond the expertise of medical practitioners, this suffering is clearly observable in clinical practice, as described above, it interacts with patients' other losses and suffering to form "total pain," meaning that it becomes a problem that cannot be ignored, and thereby becomes a societal issue.

At the 1998 World Health Assembly, the World Health Organization (WHO) laid out an amendment to its definition of health, adding the new aspect "spiritual" to the preexisting categories of physical, mental, and social.[6] There followed an enthusiastic adoption of the "spiritual" concept within end-of-life care; the aforementioned suffering regarding death was re-conceptualized under the title "spiritual pain," and "spiritual care"–care in response to spiritual pain–began to be considered within the purview of end-of-life care.

Currently, the delivery of spiritual care in clinical practice is chiefly assumed by religious figures such as chaplains. Religious figures in end-of-life care do not insist on their own religious outlooks but are members of care teams who listen to their patients' own perspectives on life and death and guide them in changing or deepening these perspectives. Indeed, there are endless examples of patients who were not previously religious discovering faith when confronted with death. While some criticize this as "the opium of the people," this is an impractical stance from the perspective of spiritual care, wherein the scientific validity of a religious worldview that includes an afterworld is not an essential question for the terminally ill patient. Moreover, the existence or non-existence of an afterworld being impossible to investigate scientifically, the question for the patient is whether to believe in this unverifiable doctrine, and there is no practical motivation for criticizing the patient's attitude. Further, if a patient is able to find hope through belief for an afterlife following the death of the body, this can be a fulfillment of patient care in removing or providing relief from spiritual pain. Contrary to the above criticism, religious care may therefore be described as an effective method that should be actively implemented. Numerous cases attest to the efficacy of spiritual care as part of holistic care, provided by religious figures and erasing feelings of tragedy regarding death.

Of course, spiritual care provided by religious figures is not always guaranteed to erase or alleviate spiritual pain. Some patients do not embrace faith even when facing death or in other critical situations, some continue to reject religious narratives, and others, despite having previously held some kind of religious outlook on life and death, find that they can no longer believe in it in their critical condition. Religion cannot always provide succor from spiritual pain. While the concept of "spirituality" is rooted in religion and should be discussed in terms of its relationship to transcendence or an afterlife, the WHO states that "'spiritual' . . . is not the same as 'religious'" and describes spirituality as an aspect of human life, including religious components, "often . . . concerned with [the] meaning and purpose [of life]."[7] Against the backdrop of the present-day decline in religion, it cannot be considered practical to rely on religious perspectives alone when responding to a terminally ill patient's awareness of death. When considering a patient's suffering regarding life and death from a realistic standpoint, it is necessary to consider a broader definition of "spiritual pain."

The introduction of a philosophical element, particularly Jaspers' existential philosophy, reveals new horizons regarding the specific nature of spiritual pain and communication in spiritual care.

3. Death as a Boundary Situation

The theory of boundary situations developed by philosopher and psychiatrist Jaspers in his chief work *Philosophy*[8] offers insights into the philosophical suffering encountered in today's clinical practice. Boundary situations "*never change*. . . . They are like a wall we run into, a wall on which we founder"; they are situations within which we exist by necessity, thereby delimiting the finiteness of humanity. Further, Jaspers proposes four "individual boundary situations"-four specific boundary situations that all will necessarily experience:[9] death (Tod), suffering (Leiden), struggle (Kampf), and guilt (Schuld).

For Jaspers, the concept of the boundary (Grenze) is not of an ultimate limit beyond which there is nothing. While, in its aspect as an inescapable wall delineating the finite nature of humanity, the boundary situation certainly engenders hopelessness and anxiety, Jaspers proposes that beyond lies a domain of Existenz that transcends objectivity, rationality, and generality. In other words, he postulates that beyond the inevitable boundary of a position that perceives the world and the self immaterially and rationally lies an existential awareness without a subject-object split (Subjekt-Objekt-Spaltung) and an awakening to an attitude toward life based on this awareness. The boundary situation is positioned as the border (Grenze) to this.

However, whether boundary situations are inevitable occurrences or not, those who have been conscious of them will not necessarily be awakened to the domain of Existenz. Of death, an individual boundary situation, Jaspers states that "death as an objective fact of existence is not a boundary situation."[10] Thus, perception of death as a mere idea or piece of information, or distortion of one's understanding of death due to false perception, results in not experiencing a boundary situation as a boundary situation. In other words, an individual boundary situation consisting of a particular occurrence is not itself a boundary situation, but becomes one only once the perceiving subject responds to it as something concerning him/herself, is conscious of his/her own finite nature, and expresses the emotions accompanying this, such as fear, anxiety, hopelessness, or absurdity.[11] Awareness of boundary situations and their accompanying emotions threatens the everyday values and rational attitudes of one's life so far and makes an appeal for an Existenz that encompasses a new domain of life. At that moment, within the sense of urgency entailed by one's awareness of a boundary situation, one undertakes a sorting of what is vital to one's own Existenz, described by Jaspers' statement that "the most innocuous act, objectively speaking, may have the weight of essentiality when Existenz comes to appear in it."[12] In other words, having become aware of our own finite nature, we reinterpret the world (Wiederholung) in terms of what we still need. Death, in particular, signifying a non-being contradictory to life and possessing a singular unknowability and impossibility of being experienced, presents a "definite boundary situation" that affirms the existence of Existenz, expressed in Jaspers' statement that "death is . . . the mirror of Existenz."[13]

Through the experience of a boundary situation, a subjective life perspective unique to the "I, here, now," and which has transcended rationality and objectivity, is decided (Entscheidung). However, an existential decision does not disregard objectivity and rationality; on the contrary, they are closely examined to produce the foundering–the awakening to the boundary–through which it is considered

essential to pass. Due to this dialectical process, a decision originating in the awareness of a boundary situation, while subjective, gains a generality definitively different from a mere arbitrary, selfish whim. However, this decision, rather than demonstrating a systematic philosophy, appears each time as the life philosophy of a single moment (Augenblick), with another moment bringing the decision of a different outlook.

Moreover, our certainty of Existenz is immediately pushed from our consciousness by the clamor of everyday life, and we are unable to live with a continued awareness of a boundary situation. Even those in harsh conditions show an instinctive desire to attempt to avoid or conceal their distress, one cannot maintain constant philosophical contemplation; on the contrary, those in distress display a tendency to attempt to proceed while ignoring the painful reality. Jaspers believed that most people do not recognize boundary situations as such and do not arrive at the certainty of Existenz, making this the subject of his own philosophical practice.[14]

4. The Possibility of Philosophizing in Modern Clinical Practice

Could Jaspers' theory of the boundary situation be integrated into concrete modern practices? In the increasingly civilized modern era, there are fewer opportunities in daily life for struggle, crime, or encountering death, thanks to developments such as stable supply of food, improved public sanitation, and reduced infant mortality. Boundary situations force our human finiteness upon us causing us to founder, but modern civilization, in expanding the range of human possibility, is succeeding in eliminating, from our daily experience and consciousness, specific events that form individual boundary situations. While society becoming plentiful and peaceful and the world developing into a reassuring place free of death may well be considered good for both individuals and the human race as a whole, modern humanity pays a price in the loss of opportunities to contemplate our lives philosophically or religiously through an awareness of our own and others' deaths. Negative events such as boundary situations create awareness of the reality of the world and of ourselves, thus playing a role in the formation of the attitudes to life and the view of life and death that can become the guiding principles of our lives. Consequently, they foster life fulfillment and the ability to respond in a crisis; yet, in the present day, there is a decline in religious belief and it is becoming difficult to understand the meaning of this kind of contemplation, let alone understand its utility.

However, even as we turn from death and strive to prolong average life expectancy, the inescapability of death remains unchanged. The fact that, despite this, people in the present day have no opportunity to encounter death in everyday life is because death in the modern age is relegated to sites where care or medical treatment is administered, locations unfrequented in the course of daily life. Following ages when, as a rule, people died at home, attended by their families, death has now become the target of medicine and has come to be managed within medical services. Further, the suffering expressed in care and medical facilities, occasioned by the awareness of death, has been termed "spiritual pain," and it is becoming a societal issue as a target of philosophical and religious care. At the same time, this situation also signifies that end-of-life clinical practice is a rare present-day scenario offering the opportunity to be aware of a boundary situation and to philosophize about life and death. In other words, spiritual care in end-of-life clinical practice could become an important base as a site in which Jaspers' philosophy can be put to practice.

This raises the question of whether terminally ill patients with no choice but to be conscious of an

approaching and inescapable death are aware of their boundary situations. As stated earlier, awareness of a boundary situation requires consciousness of one's limited reality being an inevitable and inescapable issue concerning oneself, but ascertaining objectively whether someone else possesses this consciousness presents difficulties. Further, as discussed previously, existential decisions are adopted following perception of an objective, rational boundary, and yet, no objective criterion exists by which one can clearly distinguish these decisions from simple inspiration or emotional fluctuation.

As Kübler-Ross's five-stage psychological model demonstrates, the thoughts and feelings of terminally ill patients progressively alter with the passage of time;[15] however, it would be rash to equate this with a philosophical transformation accompanied by an awareness of their boundary situations. On the contrary, modern medicine, including palliative care, tends to not only avoid creating an awareness of boundary situations, but also prevent patients from perceiving this. Administering appropriate treatment and care with respect to the patient's wishes while minimizing suffering as far as possible, "for the patient's sake," has been the patient-centered approach. For those without experiences in which individual boundary situations were a catalyst that allowed them to gain a positive view of life and death, unresolvable individual boundary situations are nothing more than negative realities that cause suffering. Possibilities that would allow the patient to be spared awareness of these boundary situations therefore become the optimal choices for the patient and medical professionals.

The societal taboo toward discussing death and suffering and the standardization and automation of decision-making relating to life and death within medical and social systems are particular drivers of this. Because people do not experience boundary situations in their everyday lives, they are ill-equipped to deal with them when they are imminent; they seek and follow the advice of "specialists" even regarding important decisions about themselves or loved ones. As specialists, medical professionals are required to provide advice from a rational and impartial perspective, resulting in decisions that are inevitably standardized to a degree. Of course, this decision-making process avoids a paternalist approach led by medical professionals; rather, decisions are made within a structure that respects the autonomy of the patient, whereby he or she selects from a number of presented options, accompanied by explanations and advice from medical professionals.

Nevertheless, choices founded on respect for autonomy are not analogous to decisions based on the patient's philosophical and religious contemplation. Patients will sometimes bow to societal or practical demands implicitly validated by medical professionals, or suppress their genuine wishes during the decision-making process due to concern for their families. While going as far as repressing one's own wishes and opt for an altruistic act is certainly one mode of autonomous attitude, the fact that the option selected by the individual is not necessarily that which is best for the individual surely merits some investigation into choice. However, choices made by patients themselves rule out further study by genuinely–both formally and psychologically–being decisions taken autonomously and freely by the patient. This is because finding the optimum for a patient cannot be guided by rationality; neither is it guaranteed purely by the patient's free choice. Also, since it is impossible to test, no question is raised about whether there could have been another better option among the various possibilities. Approaches to life cannot be judged objectively such that a structure compliant with respect for autonomy divests us of opportunities to advance further toward the optimal through criticism of autonomous decisions as they are today. Further, the medical framework is able to

manage decision-making smoothly and indirectly while maintaining its respect for autonomy sacrosanct by incorporating other practical and rational elements; this handling, under the pretext that "it is what the patient him/herself wanted," is irreproachable. In the present day, with its fully realized framework within which medical treatment that aims to alleviate suffering reaches out to and guides patients lost in the face of their boundary situations, the response to a boundary situation is not a problem contemplated philosophically or religiously by an individual, but it has come to be treated as an issue to be resolved practically by society and medical treatment.[16]

Spiritual care within the framework of medicine follows the principle of minimizing a patient's suffering, yet, according to Jaspers' philosophy, this principle becomes an impediment to the goal of maximizing the patient's QOL through holistic care. Jaspers' philosophy relating to increasing QOL–involving "philosophizing (Philosophieren)," "certainty of Existenz," "life fulfillment," and "self-realization"–requires a process in which we perceive boundary situations to concern ourselves, and despair. Jaspers postulates that beyond awareness of the hopelessness of a boundary situation is an existential life that has overcome hopelessness, and he positions this as superior to a life without consciousness of boundary situations, as expressed in his statement that "from this nothingness . . . alone can I obtain my assurance of true Existenz."[17]

However, the philosophical attitude described by Jaspers lacks supporting evidence and, as discussed above, is an abstract idea short even of standards by which to ascertain the kind of outlook that fulfills its criteria. Further, deliberately encouraging a patient suffering from illness and various other kinds of loss to turn his/her attention to death and the harsh reality is not a practical philosophy within clinical practice. The question of how to approach a patient and assume a position appropriate to his or her mental state is important in clinical practice, and acting against the patient's wishes beyond the realm of medical treatment is unacceptable. While it is the wish of the patient (care recipient) that is respected in the patient-centered approach, it is the decision made by the patient (person) after correctly recognizing the world and him/herself that is respected in philosophy. The former functions rationally and systematically, while, the latter is subjective and makes no promise to eliminate suffering. As a result, it is impossible to prove that philosophizing in clinical practice is superior to the patient-centered approach.

5. "Loving Struggle" as Existential Communication

Because medicine is a social service, the patient cannot, in principle, be given unnecessary suffering. Further, so long as treatment and care are administered in compliance with ethical principles, such as respect for autonomy, this attitude is irreproachable. However, there are patients who contemplate and agonize over their own lives and deaths, and, among them are those who hide their own suffering and are unable to discuss life and death owing to their concern for others. A compliance by medical professionals in their capacities as specialists of questions of appropriate treatment and even of respect for autonomy regarding these patients could be considered a thorough fulfillment of their duties. However, is there another way to improve patient QOL, beyond the performance of one's duties as specialists–as human beings approaching these suffering patients?

For Jaspers, this would simply be philosophizing in the awareness of one's boundary situation, but a specific method for this can be suggested in the form of "existential communication." Awareness of a boundary situation, particularly in the current era of religious decline, entails a sudden critical

viewing of one's prior values and way of life based on a general, rational, and practical worldview, and a sinking into despair, regret, and a sense of meaninglessness; yet, when we yearn for something and strive to live despite this, the philosophizing begins. This "something" can be described as a subjective life outlook drawn from the domain of Existenz, or as "subjective truth." Necessary to reach this is the existence of other people. Jaspers states that boundary situations "rend all conclusive being and thus show the doubtfulness of all we know. But it is in those situations alone that man begins the unconditional activity in which his self turns toward another self."[18] In other words, when one who has perceived a boundary situation and experienced hopelessness seeks to escape his or her present discontent and sense of powerlessness, he or she becomes aware of the boundary of what is attainable by a single, limited human and seeks out others. This is not, however, an entrusting of all points of reference to another as in the placing of one's faith in a god in a religious context, but rather, a position of collaborative philosophizing with the other (Symphilosophieren) to consider one's own unique life outlook, even while aware of one's own narrow scope.

Existential communication is neither the communication of knowledge from one party to another nor the collaborative discovery of shared answers as in academic research. While general knowledge can be useful, it is never enough in boundary situations and is merely something that must be surmounted. Beyond that kind of shareable fact are subjective decisions, attitudes unique to the individual due to that very subjectivity and by no means derived from compromise with others. The goal of existential communication is for those who have become aware of a boundary situation to discover one another's unique attitudes. In other words, it is not for one unaware of a boundary situation to impart something to the other, nor is it for one or the other to be the focus. Further, as this communication deepens, each party comes to understand the other, while, simultaneously, the differences between the self and the other become clear, precisely because both parties seek out the other's unique life outlook. Attitudes that do not permit accommodation of the other bring a sense of isolation as they concurrently increase feelings of solidarity.

The most significant feature of existential communication is that it is held to be a form of "struggle," one of individual boundary situations. In other words, it does not entail an amicable relationship in which both parties benefit the other, but one in which it is sometimes necessary to hurt or distress the other. This is because the reality of the boundary situation is one that inevitably causes suffering. Existential communication is the suspension of one's sociable nature, the deliberate confrontation of the hopeless reality that we prefer not to consider or approach in daily life, without hesitating to cause suffering to one's interlocutor, and the revelation of one's individual perception of the world and oneself to the other, all to achieve an "instant" of life in this world without discontent. For this to happen, there must be unreserved openness, equality, and trust between the two parties, and an absence of self-interest, shame, hesitancy, and similar feelings. Jaspers describes this relationship as "loving struggle (liebender Kampf)," an irreplaceable relationship in which we confront one another without recourse to violence or authority and at risk to ourselves for the sake of the truths of each party. The "love" of this loving struggle is not the Christian benevolence that aims to give to the other (Caritas), but Socratic love that seeks truth alongside the other (Eros).[19]

Within this philosophical relationship, there is no guiding toward a subjective decision in the form of choosing a particular option from a selection thought up by the other party. Although beginning one's contemplations with an investigation into the preexisting options can certainly be useful, philosophizing emphasizes the drawing up of options within a free state without presuppositions.

Considering, without preconceptions, what can be done in the "I, here, now" and deciding from among these possibilities the attitude most valuable to one's life, while revealing the self, perceiving the differences and uniqueness of the life of another through contact with it, and correctly perceiving oneself and the world, is one autonomous act, as is choosing something that suits one from the choices offered by one's pre-existing rational, general, and practical values–yet these are completely different operations in philosophical terms.

6. Those Philosophizing Together and Those Supporting the Philosophizing

For those experiencing spiritual pain, the important thing is that which supports the life of the "I, here, now." For the person in suffering and isolation, another person who supports them in this is necessary, and this is exactly the role fulfilled by the palliative care teams of terminally ill patients. Of course, from the perspective of total pain, it is indisputable that systematic treatment based on guidelines and other frameworks is necessary, as care that improves the patient's physical, mental, and social situation is clearly effective for spiritual pain, while understanding the spiritual aspect as objectively as possible can surely be considered a necessary task when considering the optimal course in specific aspects such as cancer treatment options. However, decisions made existentially are based on a freedom that transcends rationality and objectivity and may therefore conflict with medical norms, as in the case of Jehovah's Witnesses' refusal of blood transfusions; moreover, they offer no guarantee of a happy result. The subjective truths brought forth through existential communication must go beyond right and wrong as prescribed by rational and societal values, bypassing concerns about suffering of our communication partners. A means of philosophizing that embraces attendant risk and leaves preconceptions behind, existential communication can admit even suicide and thus presents dangers when treated as a mode of spiritual care as part of medical services; there is no duty or obligation to do so. However, it is also true that the existence of another person with whom to share this suffering and contemplate attitudes to life increases QOL for patients experiencing spiritual pain.

Who could this other person be who could enable existential communication in clinical practice? Jaspers alludes to the possibility of existential communication between physician and patient.[20] The physician is certainly in a superior position relative to the patient in terms of physical, mental, and social situation, and it is undeniable that he or she administers treatment based on his or her authority as a physician. However, communication by means of this authority is "only a part, never the whole, of the doctor's attitude to the patient."[21] A doctor can also communicate in his or her role as "not a pure technician nor pure authority, but Existence itself for its own sake, a transient human creature like his [or her] patient."[22] On the specifics of existential communication, Jaspers merely states that it is not something that can be expressed by a code of conduct[23] and so "it is not theory but [the] example [of the psychotherapist able to take part in existential communication] which teaches us what manner of man he may be."[24] This kind of communication between human equals without any shrinking from the other can surely be seen in scenes of palliative care and the wordless contact that Mother Theresa practiced in her "Home for the Dying." However, from a broad perspective, medical professionals have a societal existence that carries the responsibility and obligation to provide a service, and they may find it difficult to take the risk of challenging the status quo by deliberately causing a patient suffering. Further, pouring tremendous time and effort into the

specialist work with which they are entrusted in a modern medical system that does not currently provide an environment conducive to their philosophizing is impossible.

The first alternatives to medical professionals as existential communication partners are family and friends. Family and friends know the patient well and a relationship of trust is already established. Furthermore, they do not have the responsibilities and professional restraints, such as non-maleficence, shared by medical professionals, thereby fulfilling the conditions for open and equal discussion of life and death. However, family members have their own particular concerns precisely because of the involvement of their loved ones. Societal familial obligations, diffidence and shame over being too intimate, pride that prevents willingness to show weakness, hesitancy to bring up a topic that is for their own benefit, and, above all, concern over sufferinging the other party by facing the negative reality all currently form a barrier to existential communication within the family. Nevertheless, it is undeniable that the ideal other for existential communication is a beloved family member or friend. This is because the patient's family and friends, as the people who make up his or her reason for living, have a high likelihood of being directly connected to the life outlook at which the patient will arrive. Moreover, their existential communication with the patient can lead, through their own concurrent contemplation, to philosophically and socially valuable results in their discovery of views of life and death and outlooks that alleviate grief, which can come to guide them in their own lives. In other words, this is a returning to daily life of the boundary situations that are usually relegated to the sites of care and medical treatment–unfrequented in the course of everyday life–and treated systematically.

In truth, most patients are unlikely to actively look for an opportunity to disclose their own suffering and hopelessness, out of concern for medical professionals and their families and friends. In terms of treatment, this is not a problem and there is no norm or comparison by which this is judged to be an erroneous attitude. However, although there are no clear standards or proofs, there are personal examples of other parties undertaking existential communication and of patients' QOL being improved, and there is surely sense in creating environments open to that possibility. In concrete terms, these environments where patients and their families and friends could discuss their own lives and deaths without anxiety are likely to be found in environments created by third parties. I will not provide a detailed description of the means of creating such spaces here, but with boundary situations being currently relegated to the site of medical treatment and care, the creation of these environments should be the work of medical professionals or specialist treatment teams.

Conclusion

Treating illness and removing suffering as far as is possible is the goal of medicine, yet this is not the aim of human life. Health is but a means to the end of living. Despite this, current medical treatment that aims for health and the absence of suffering is causing a distortion that determines human attitudes to life and death. Furthermore, this distortion is being left to take its course due to a principle that states that we cannot judge human life objectively. This distortion and its neglect, perpetrated in the sites of clinical practice to which boundary situations have been relegated and which we do not ordinarily encounter, have led to the current situation in which we are deprived of the possibility of living better in philosophical or religious terms.

Transcending the framework of medical treatment to open the possibility of philosophizing in

clinical practice is a practice recommended by both clinical practice and philosophy, as a means of alleviating patients' suffering, promoting views of life and death in those around them, and guiding contemplation of every unique attitude to life.

Notes

1. R. M. Veatch, "Models for Ethical Medicine in a Revolutionary Age," *Hastings Center Report 2* (1972).

2. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 6th ed. (Oxford University Press, 2008).

3. Various other forms of medical ethics principles have been proposed, including Engelhardt's two guiding principles of autonomy and beneficence, see H. T. Engelhardt Jr., *The Foundations of Bioethics*, 2nd ed. (Oxford University Press, 1996).

4. Talcott Parsons, "Service," *Encyclopedia of Social Sciences* (Seligman, 1954): 672-674.

5. The concept of "service" as used in this paper is based on Parsons' definition and does not approach medicine from the perspective of an economic model.

6. "Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity."

7. WHO, "Cancer Pain Relief and Palliative Care," *Technical Report Series*, no. 804.

8. Karl Jaspers, *Philosophie II: Existenzerhellung* (Springer, 1956); Karl Jaspers, *Philosophy 2*, trans. E. B. Ashton (Chicago and London: The University of Chicago Press, 1970).

9. In *Philosophy 2*, Jaspers divides boundary situations into the three broad sections concerning historic delimitation, individual boundary situations, and the antinomical structure of existence.

10. Jaspers, *Philosophie II*, 220, Jaspers, *Philosophy*, 193.

11. F. Peach classifies boundary situations perceived as such as "actual boundary situations" and names those "potential boundary situations" where the subject does not have this awareness "Grundsituation," see Filiz Peach, *'Deathlessness' and Existenz in Karl Jaspers' Philosophy* (Edinburgh, 2008): 63.

12. Jaspers, *Philosophie II*, 223, Jaspers, *Philosophy 2*, 196.

13. Jaspers, *Philosophie II*, 222f, Jaspers, *Philosophy*, 195f. Jaspers's consideration for the special position of one's own death as an opportunity for authenticity (Eigentlichkeit) was shared by Heidegger.

14. In his "das Man" concept, Heidegger presents humanity's basic mode of existence as one in which Existenz is obscured by the everyday. These ideas were not confined to existentialism, with Pascal theorizing in his concept of "diversion" (divertissement) that the fundamental nature of human existence is the fleeing of death, see Blaise Pascal, *Pensées* (Garnier, 1974): 119.

15. Using data from her own clinical practice, Kübler-Ross divided the mental state of the terminally ill patient into the stages of denial, anger, bargaining, depression, and acceptance, see Elisabeth Kübler-Ross, *On Death and Dying* (Macmillan Publishing Company, 1969): 235.

16. Ivan Illich, *Medical nemesis: the expropriation of health* (Pantheon Books, 1982).

17. Jaspers, *Philosophie II*, 227, Jaspers, *Philosophy 2*, 198.

18. Jaspers, *Philosophie II*, 106, Jaspers, *Philosophy 2*, 94.

19. Hans Saner, *Einsamkeit und Kommunikation* (Lenos Verlag, 1994): 18.

20. In his *Allgemeine Psychopathologie*, Jaspers presents a neurologist conducting psychotherapy as a candidate for a physician able to take part in existential communication, see Karl Jaspers, *Allgemeine Psychopathologie*, 9. Aufl. (Springer, 1973); Karl Jaspers, *General Psychopathology,* trans. J. Hoenig and Marian W. Hamilton (Manchester: Manchester University Press, 1972).

21. Jaspers, *Philosophie II*, 673, Jaspers, *Philosophy*, 805.

22. Jaspers, *Philosophie II*, 668, Jaspers, *Philosophy*, 798f.

23. Moreover, Jaspers states that an affinity between physician and patient is also important for establishing existential communication, see Jaspers, *Philosophie II*, 676f, Jaspers, *Philosophy*, 806.

24. Jaspers, *Philosophie II*, 674, Jaspers, *Philosophy*, 806.